Long Term Care Institute, Inc.

Menu

LTCI-VA Survey Web Site

Department of Veterans Affairs Community Living Center Survey Report

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This document or report and the information contained herein, which resulted from the Community Living Center Unannounced Survey, has been de-identified to remove individually identifiable health information (also known as protected health information) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and other federal and state laws. De-Identification was completed in accordance with guidance published by the Office for Civil Rights to protect the privacy of the Community Living Center's residents.

General Information:

Location: Edward Hines Jr. VA Medical Center (Hines, IL)

Onsite or Remote: Remote

Survey Modality: Full Virtual

Dates of Survey: 5/19/2021 to 5/21/2021

Total Available Beds: 173

Census on First Day of Survey: 110

F-Tag	Findings
F584 483.10(i)(1)-(7) *§483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide—§483.10(i)(1) A safe, clean,*	Based on observation and interview, the CLC did not ensure maintenance of comfortable sound levels. Findings include: [LOCATION] • On 05/19/21 at 1:30 p.m. Resident #201, who had a Brief Interview for Mental Status score of 15 suggesting intact cognition on the 05/03/21 MDS, was interviewed in his room with the registered nurse (RN) liaison and nurse manager present. The intercom paging system interrupted the interview between the resident and surveyor to the extent that the conversation had to be halted until the overhead paging ended. The overhead paging was an announcement by staff working in the neighborhood requesting assistance in another

comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels.

Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy

Residents Affected - Few

resident's room. On 05/20/21 from 11:40 a.m. until 12:40 p.m., Resident #201 was again interviewed. During the interview, the overhead paging was loud and interrupted the conversation on two different occasions and as a result, the resident was unable to be understood. The overhead paging was used by staff to request assistance stating, “Isolation trays – need assistance…all staff needed in dining room….” Resident #201 expressed concerns about the noise level from the overhead paging.

- On 05/20/21 at 1:25 p.m., a registered nurse (RN) was observed during medication administration for a resident who resided in the [LOCATION] neighborhood. The RN was observed standing in the hallway just outside the entrance to a resident’s room as she prepared medications after scanning them. The surveyor had to ask the RN to repeat the names of the medication since the overhead paging system made it difficult to hear the information provided by the RN. The nurse manager was present during the observation and acknowledged the noise level from staff paging and stated she was “looking at other options” to reduce the noise levels that made it difficult to hear relevant resident care information.
- On 05/20/21at 3:30 p.m., the [LOCATION] nurse manager indicated that the [LOCATION] Resident Council meeting was in session. The surveyor attended the meeting with permission from the residents in attendance. During the meeting, overhead paging made it difficult at times to hear the acting Resident Council president speaking on behalf of the six residents in attendance.
- On 05/21/21 at approximately 2:00 p.m., a meeting was held with CLC leadership and representatives from the quality management staff. The surveyor shared concerns regarding the disruptive sound levels in the [LOCATION] neighborhood related to overhead paging. No additional information was provided.

F585

483.10(j)(1)-(4) *§483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice*

Based on observation, interview and record review, the CLC did not take steps to investigate resident grievances and provide feedback on pertinent findings or conclusions regarding resident concerns. Findings include:

grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written

The CLC provided a copy of the "Standard Operating Procedure Patient Rights and Responsibilities" that was dated 03/10/21 and indicated, "Responsibilities….c. The Chief Nurse, Long Term Care and Specialty Services (or designee) is responsible to inform LTC [long-term care] residents of Hines' Extended Care Center (ECC) or Residential Care Facility (RCF) of their rights and responsibilities while a resident in LTC Services….Other Paragraphs….Patients admitted to Long Term Care Services will be provided an Extended Care Center/Transitional Care Unit Patient/Resident & Family Handbook and a signature of receipt will be obtained. Residents admitted to the RCF will be provided the Resident Handbook and a signature of receipt will be obtained."

The CLC provided a copy of the "Resident and Family Information Handbook Spinal Cord Injury/Disorder SCI/D…Residential Care Facility." The handbook indicated, "Complaint process….You are encouraged and assisted throughout your stay to exercise rights as a resident and as a citizen. There are several ways, identified below, whereby you may voice concerns or complaints and recommend changes in policies and services." The handbook indicated the Resident Council, suggestion box, and access to the consumer representative (name of nurse manager) were provided as ways residents could express concerns. The handbook did not indicate the procedure as to how a grievance was addressed or resolved, or how the resident would be provided with evidence of progress toward resolving a concern expressed by a resident or group of residents.

Resident #201, [LOCATION]

- Resident #201 was admitted to the CLC on [DATE] and had diagnoses that included quadriplegia; the resident required the use of a tracheostomy.
- The resident's comprehensive Minimum Data Set (MDS) dated 05/03/21 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 and was dependent upon assistance from one staff person with eating.
- On 05/19/21 at approximately 9:05 a.m., the nurse manager and assistant nurse manager were interviewed during the initial tour and indicated that Resident #201 was alert and oriented.
- On 05/19/21 at 1:30 p.m. Resident #201 was interviewed in his room with the registered nurse (RN) liaison and nurse manager present. During the interview, the resident expressed concerns about the food served at the CLC, indicating the food was "often cold." The resident agreed to continue the interview at a later time.
- On 05/20/21 from 11:40 a.m. until 12:40 p.m., Resident #201 was interviewed and indicated that he had concerns with the food stating, "It's horrible." When the surveyor asked what he meant, the resident stated, "We appreciate what the VA does for us…but I've been here for three and one-half years and it's the same food…it gets old…there's no variety at all. I can tell you the menu off the top of my head." When asked if alternative food items were available from the menu, he responded, "Yes, but that is the same old food too." The resident further indicated, "The taste and texture of the food is not good…there's no variety." When asked if he reported his concerns to CLC staff, he stated, "Yes. Nothing changes…this is not new. I am not the only one who complains." The resident further indicated that he had attended Resident Council meetings in the past, the topic of food was commonly addressed, and that staff were aware of the residents' concerns. Resident #201 said staff responded to concerns by indicating, "They will look more into it…will check with the dietitian." The resident indicated, "Food plays the biggest part of life, can diminish you [your quality of life], if you have to eat a certain way….It's the variety of food….If you order a salad, you just get lettuce, no croutons, no meat, no cheese, just lettuce."
- On 05/20/21 at approximately 2:00 p.m., the [LOCATION] registered dietitian (RD) was interviewed and indicated that the neighborhood and hospital followed a "three week cycle menu" which meant that every three weeks the food selections would repeat. The RD

decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the

indicated that she was aware of the food concerns stating Resident #201 and other residents "want more variety" but few changes could be made in the pre-established menus. The RD indicated, "About a month ago, food could be ordered from the canteen;" however, the RD was not certain that practice continued. At approximately 2:15 p.m., the [LOCATION] nurse manager indicated that the ability to order food from the canteen for delivery to the neighborhood ended, "about a month ago…residents can now order food to be delivered [from local restaurants]….dropped off at the front [entrance]."

Resident #204, [LOCATION]

- Resident #204 was admitted to the CLC on [DATE] and had diagnoses that included [DIAGNOSIS] and quadriplegia. The physician's diet order dated 07/17/19 stated, "Veterans Choice" meal plan.
- The resident's quarterly Minimum Data Set (MDS) dated 04/05/21 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 suggesting the resident was cognitively intact. Resident #204 was the acting [LOCATION] Resident Council president.
- On 05/20/21 at 3:30 p.m., the [LOCATION] nurse manager indicated that the [LOCATION] Resident Council meeting was in session. The surveyor attended the meeting with permission from the residents in attendance. Resident #201 (who was interviewed as above) was not present during the Resident Council meeting. Resident #204 indicated that he had lived in the [LOCATION] neighborhood for the past five years and food concerns were not new since he had been a resident in the neighborhood. There were representatives at the meeting from food and nutrition services including the food service supervisor who acknowledged that he was aware of the resident concerns about food. Resident #204 discussed several meal related issues, including meal delivery and the lack of variety of food choices. Resident #204 further stated, "The meal redundancy cycle menus…." and clarified that the menu repeats and the same foods were available as alternates. He stated, "We asked for changes…need more diversity on the menu."
- On 05/21/21 at approximately 8:10 a.m., the [LOCATION] RD was interviewed and acknowledged that Resident #204, and other residents in the neighborhood had expressed concerns about the lack of "menu variety;" the RD indicated she was unable to make changes to the menu and could only report resident concerns to the chief of food and nutrition services but could not make any systems-level changes. The RD indicated that the "Veterans Choice" menu was essentially a regular diet with the ability for the resident to make meal choices based upon preferences.

[LOCATION] Resident Council Minutes

- Resident Council meeting minutes titled, "[LOCATION] Resident Council" included the following pertinent information:
  - 02/25/21 "Old business 11/21/19 – Reported issues with food quality, meal trays sometimes are incorrect, do not reflect selections made….In progress NFS [nutrition and food service] continues to follow-up, ongoing issues…meet monthly to discuss." The information was gathered by the [LOCATION] recreational therapist who documented, "Recreation therapy meets with individual residents to ensure issues/concerns expressed."
  - 03/18/21 "New business – Several residents reported issues with their meal trays. Tossed salad consists of many [mainly] lettuce with one or few other vegetables mixed in it....Residents continue to report issues with food quality and meal tray accuracy. Old business – Dietary – 11/21/19 [same information documented as noted in the 02/25/21 Resident Council report]."
  - 04/15/21 "Residents now allowed to order outside food every day of week, 10am-6pm. [10:00 a.m. to 6:00 p.m.] Residents allowed to go to canteen/patriot store, have 30

steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.

Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy

Residents Affected - Some

minutes time limit and are expected to sign-in/out. Old business – meal trays 03/18/21 – [same information as documented on 02/25/21 and 03/18/21]."

Additional Resident Interviews

Resident #105, [LOCATION]

- During observations on 05/19/21 at 12:52 p.m., Resident #105 expressed concerns about the temperature and taste of the food; the resident's meal included a grilled cheese sandwich and potato wedges. The resident stated, "It's not hot enough." The "cook supervisor" was present and obtained the temperature of food on the resident's meal tray that the resident stated was not hot. The temperature of the potatoes was 117 degrees F. During a follow-up interview with the cook supervisor, he stated the food was prepared in a separate building and delivered to the CLC; meal trays delivered to [LOCATION] and [LOCATION] were delivered in warming carts and the last meal trays to be delivered. The cook supervisor agreed the temperatures were low at the point of service, meaning when the trays were delivered to residents in [LOCATION] and [LOCATION].

Resident #101, [LOCATION]

- During observation of the noon meal on 05/19/21 at 12:40 p.m., in Resident #101's room, the resident stated, "The food does not have any taste and is not hot."

Resident #102, [LOCATION]

- During observation of the noon meal on 05/19/21 at 1:15 p.m., Resident #102 expressed concerns about the taste and temperature of the food; the resident's meal included a hamburger and potato wedges. The resident said, "It's doesn't taste good, it's not seasoned and the hot foods are rarely hot." The cook supervisor obtained the temperature of the hamburger that was on the resident's meal tray; the hamburger was 115 degrees F and the potatoes which were 100 degrees F.

Resident #103, [LOCATION]

- During observation of the evening meal on 05/19/21 at 5:30 p.m. in the resident's room, the resident stated, "The food is always cold." Most of the meal was uneaten and still on the resident's plate.

Resident #104, [LOCATION]

- During observation of the evening meal on 05/19/21 at 5:45 p.m. in the resident's room, the resident stated, "I don't like the food." The resident was not specific as to why he did not like the food. When asked if alternates or substitutes were available, the resident said, "I don't know."

Systems-Level Review

- On 05/21/21 at approximately 11:30 a.m., the chief of food and nutrition services who was an RD, was interviewed along with several other RDs and several CLC leadership team members. The chief of food and nutrition service acknowledged that there were "long standing concerns [related to food], many steps have been taken to try to resolve issues…we know we are not there yet. We do not have enough [dietary] staff to get the meal trays out as quickly as the residents would like them." The RD further indicated that she planned to convene a team to look at the issues and develop a plan of action to address the resident's concerns.

- On 05/21/21 at approximately 2:00 p.m., a meeting was held with the CLC leadership team and representatives from quality management to share concerns expressed by the residents who lived in the [LOCATION] neighborhood. There was no further information provided or questions from the team regarding the identified concerns. The [LOCATION] nurse manager was present during the interview and when the surveyor asked if the CLC had a grievance policy or procedure, the nurse manager indicated, “We do not have a grievance policy. We have a patient handbook that provides guidance as to how resident concerns are to be handled [as indicated above].”

F686

483.25(b)(1)(i)(ii) *§483.25(b) Skin Integrity. §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that— (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual’s clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.*

Level of Harm - Actual harm that is not immediate jeopardy

Residents Affected - Few

Based on observation, interview and record review, the CLC did not ensure that residents received care consistent with professional standards of practice, to prevent pressure injuries/ulcers from developing unless resident clinical condition demonstrated that they were unavoidable. Findings include:

On 05/20/21 the CLC policy titled, “Pressure Injury Prevention and Management” and dated 05/28/20, was provided by CLC staff. According to the policy, “Unavoidable Pressure Injury. An avoidable pressure injury is a pressure injury that develops even though the provider has evaluated the individual’s clinical condition and pressure injury risk factors; defined and implemented interventions that are consistent with individual needs, goals, and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate….”

Resident #403, [LOCATION]

- Resident #403 was admitted to the CLC on [DATE] after a fracture to the right proximal tibia/fibula following a fall that occurred at another facility on 03/24/21. During the initial tour on 05/19/21 at approximately 8:45 a.m., a neighborhood RN indicated that Resident #403 had a surgical wound and “two small decubitus [pressure injuries/ulcers] on his back due to his pain with repositioning. He is incontinent and needs to be kept clean and dry. He has heel protectors and he doesn’t like them.”
- According to the resident’s comprehensive MDS dated 04/08/21, the resident understood and was understood by others, had a Brief Interview for Mental Status (BIMS) score of 9 suggesting moderately impaired cognition, and rejected care four to six days during the review period; the resident required extensive assistance with bed mobility and total assistance with transfers. The MDS was coded to indicate the resident had functional limitations in range of motion in the upper and lower extremities on one side, used an indwelling urinary catheter, and was continent of bowel. The MDS indicated the resident was at risk for pressure ulcer development and had one Stage 1 pressure injury and one Stage 2 pressure ulcer. Skin and wound treatments coded on the MDS included pressure reducing devices for the resident’s chair and bed, a turning and repositioning program, nutrition or hydration interventions, ulcer care, and application of dressings and ointments/medications other than to the feet.
- The resident’s baseline care plan dated 04/05/21 included a concern related to “Integumentary Systems” and indicated the resident had a Stage 1 pressure ulcer on his right heel that healed on [DATE] (prior to admission), and a Stage 2 pressure ulcer on the sacrum that healed.
- The resident’s current care plan dated 04/19/21 stated, “Mepilex site: sacrum- frequently q [every] 3 days peel and peek. Air loss mattress. Skin inspections. Staff to implement pressure ulcer prevention measures as needed. Low air loss mattress, turn and reposition q [every] 2 hours while in bed, reposition every 15 minutes while in chair or wheelchair, elevate heels using Prevalon boots or pillows, proper cushion in wheelchair.” The care plan was

modified on the following dates as indicated below:

- 04/21/21 “Refusals for wound dressing and refusals for wearing Prevalon boots.” Causal and contributing factors to the resident’s refusal of care (e.g., pain) were not identified with approaches. Alternative approaches to Prevalon boots, turning and repositioning, etc. had not been developed to prevent pressure injuries/ulcers.
- 04/22/21 “Impaired Skin Integrity” related to DTPI [deep tissue pressure injury] to R [right] lateral heel and DTPI on right great toe.”
- 04/25/21 “Heels must be constantly off surface either by heel boots or pillows, turn and reposition tap 2 [Prevalon® Turn and Position System], elevate heels in heel boots, air mattress.”
- 04/27/21 “Cleanse Left gluteal region with theraworx[,] apply sacral Mepilex every 5 days and prn [as needed].”
- 04/27/21 “DTPI update to L [left] gluteal region resolved into a stage II [2] PI [pressure injury].”
- 04/30/21 “Out of bed daily for 1 hour. Apply Mepilex to bilateral heels. Prevalon boots at all times in bed.”
- 05/05/21 “DTPI on R [right] buttock noted. Knee gatch position while on back to prevent sliding….DTPI R heel.”

- According to nursing notes dated 05/05/21 through 05/19/21, the resident refused care on the following dates:
  - 05/05/21 Refused Prevalon® boots
  - 05/06/21 Refused Prevalon boots
  - 05/09/21 Refused Prevalon boots
  - 05/15/21 Refused repositioning
  - 05/17/21 Refused repositioning
  - 05/18/21 Refused repositioning
  - 05/19/21 Refused Prevalon boots, “elevated BLE [bilateral lower extremities] with 1 pillow.”
- On 05/20/21 at 12:30 p.m., the NM indicated that the resident was seen by orthopedics to remove an exposed pin in the right knee surgical wound. The resident left at approximately 9:30 a.m. with an escort service on a stretcher and returned at approximately 1:15 p.m.
- The CLC wound care nurse (WCN) from the wound care team was interviewed on 05/20/21 at 12:45 p.m. According to the WCN, a consult was received on 04/22/21 for moisture associated skin concerns and deep tissue pressure injuries over the resident’s “Right heel and right great toe.” The treatment plan included, “Offloading heels and turning in bed.” The WCN indicated that on 04/28/21, the WCN saw the resident for a “new DTPI to left buttocks” and added that the resident was in “a considerable amount of pain.” When asked if she thought the pressure ulcers were avoidable, the WCN said, “The complicating factor was pain and him being adamant of what he wanted to have done. I can’t say they are avoidable.” The NM added that the resident refused to be repositioned or to wear heel protection.
- On 05/21/21 at 9:55 a.m., Resident #403 was observed lying on his back in bed with the head of the bed raised approximately 45 degrees. The resident was lying on a low air loss mattress and had both lower legs elevated on top of pillows. The resident’s heels were floated and were not touching the mattress. The [LOCATION] wound care registered nurses (RN), a second RN, and a nursing assistant were present during the observation, along with the nurse manager, RN liaison and RN observers from the CLC and quality management team. During the observation, the resident was wearing an adult brief and used an indwelling urinary catheter. When the resident was turned to the right side, Mepilex dressings dated 05/20/21 were observed over the right and left buttocks and sacral area. The dressing on the left buttock was removed by the wound care RN and she stated, “It was a DTI [deep tissue injury]; now it’s resolving [healing] wound…stage 2.” After removing the dressing from the

right buttock, the wound care RN said, the "right coccyx [buttocks] wound was a DTI…now stage 3, 100% slough." When asked how she believed the wounds developed, the wound care RN indicated, "He doesn't let us know when he's incontinent….we check him every 2 hours, sometimes hourly….we asked him to remind us but he hasn't been doing that and he does not like our repositioning devices, especially pillows." After the resident was assisted to his back, the wound care RN and nursing assistant lifted his right leg onto a pillow; the resident's right foot appeared to be shaking; the resident called out in a loud tone of voice and raised his right hand to his forehead and covered his eyes. The staff were asked if the resident was experiencing pain or discomfort and when the wound care RN asked the resident, he stated, "Yes. My knee." The nurse manager was further interviewed and indicated, "He came to us in such a great deal of pain. If he lays [in bed] he gets sores…we tried to get a hold of his pain. He won't move." The nurse manager indicated that on the prior day the resident "spent the whole day in the ortho [orthopedic] clinic…they took out a screw [in the resident's right knee]."

- On 05/21/21 the NM stated, "It takes more than two [staff] to do dressing changes because he is in so much pain every day, just moving him." The NM indicated that the resident frequently refused to be repositioned or to wear his boots. The NM said that the resident was discussed in watch list huddles that the psychologist participated in, but that no "bedside evaluation" had been completed to determine why the resident was refusing to be repositioned or wear heel protectors. When asked if the CLC had conducted an assessment to determine why the resident was refusing to be repositioned or wear heel protection (Prevalon boots), the NM indicated there was no documentation as to why he refused; the NM thought it was "related to his pain."
- In summary, Resident #403's baseline care plan dated 04/05/21 included a concern related to "Integumentary Systems" and indicated the resident had a Stage 1 pressure ulcer on his right heel that healed on [DATE] (prior to admission), and a Stage 2 pressure ulcer on the sacrum that healed. Updates to the care plan indicated the resident developed pressure injuries/ulcers as follows: 04/22/21 "Impaired Skin Integrity" related to DTPI [deep tissue pressure injury] to R [right] lateral heel and DTPI on right great toe;" 04/27/21 "DTPI update to L [left] gluteal region resolved into a stage II [2] PI [pressure injury];" and 05/05/21 "DTPI on R [right] buttock noted….DTPI R heel." Resident #403 was admitted to the CLC on [DATE] after a fracture to the right proximal tibia/fibula; staff reported during the survey that the resident refused to be turned and repositioned and refused to wear Prevalon boots due to pain. Causal and contributing factors to the resident's refusal of care (e.g., pain) were not assessed with approaches identified to address the resident's risk for pressure injuries. Alternative approaches to Prevalon boots, turning and repositioning, etc. had not been considered and the effectiveness of the resident's pain management had not been evaluated in an effort to improve the resident's comfort to facilitate turning and repositioning and other pressure reducing interventions.(See Quality of Care, Pain Management)

Resident #202, [LOCATION]

- Resident #202 was admitted to the CLC on [DATE] with diagnoses that included dementia, delirium, pressure ulcers to the sacrum and left heel, status post right below the knee amputation, and kidney failure requiring hemodialysis.
- The resident's comprehensive MDS dated 04/27/21 indicated the resident had a BIMS score of 12 suggesting moderately impaired cognition, rejected care four to six days during the review period, experienced other behavioral symptoms not directed toward others one to three days during the review period, and required extensive assistance with bed mobility. According to the MDS, the resident was at risk for pressure ulcer development and was admitted to the CLC with two Stage 1 pressure ulcers and three vascular wounds. Skin and ulcer/injury treatments coded on the MDS included pressure reducing devices for the

resident's bed and chair.

- The resident's care plan dated 04/27/21 indicated, "Integumentary – admitted with stage 1 gluteal regions healed on 05/05/21, developed stage 1 left heel and healed on 05/17/21…status post right below knee amputation on 04/12/21 secondary to peripheral vascular disease." The approaches included, "Prevalon boots…."
- On 05/19/21 at approximately 10:20 a.m., the nurse manager indicated the resident resisted care, was aggressive with staff at times with threatening verbal behavioral symptoms, and at one point tried to remove a dialysis catheter. As a result, the CLC care team decided to have a nursing assistant (NA) remain with the resident at all times for one-on-one care and supervision.
- On 05/19/21 at 12:10 p.m., Resident #202 was observed sitting in bed positioned with the head of the bed raised approximately 45 to 90 degrees while the resident was eating independently, and an NA was present in the room. The resident's feet could not be visualized. At approximately 4:00 p.m., the resident was observed lying in bed positioned on his right side and appeared to be sleeping while an NA remained in the room. The resident's feet could not be visualized. The resident was observed to use a "high-low Stryker" bed that had a "low air loss" pressure reducing mattress.
- On 05/20/21 at 8:15 a.m., Resident #202 was observed to be awake and lying in bed on his back with the head of the bed raised approximately 30 to 45 degrees. During the observation, a registered nurse, health care technician, and nursing assistant were in the room. The resident's left foot was observed to have a yellow antiskid sock in place and the bottom of his foot rested directly against the footboard. When an NA pulled the blankets back from the resident's left lower leg, the resident had no pressure reducing (Prevalon) boot in place, and the left heel was not offloaded from direct contact with the surface of the mattress. When the staff removed the resident's left sock, there was no evidence of skin alteration. A registered nurse examined the left foot and stated, "His heel is pink, blanches, [and is] not boggy." The nurse manager was present and directed staff to move the resident up in bed since his left foot was pressed against the foot board and pressure was not offloaded from his left heel.

F689

483.25(d)(1)(2) *§483.25(d) Accidents. The facility must ensure that – §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.*

Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy

Residents Affected - Few

Based on observation, interview and record review, the CLC did ensure the resident environment remained free of accident hazards. Findings include:

On 05/21/21, the RN liaison provided a policy titled, "Use of Restraints" that was dated March 1, 2021. The policy did not address side rails except use of four side rails and did not address an assessment related to side rail safety.

Resident #401, [LOCATION]

- Resident #401 was admitted to the CLC on [DATE] with diagnoses that included Parkinson's disease, posttraumatic stress disorder (PTSD), and spinal cord compression with incomplete paraplegia.
- According to the resident's comprehensive MDS dated 03/29/21, the resident had impaired vision, was usually understood and usually understood others, had a Brief Interview for Mental Status (BIMS) score of 11 suggesting moderately impaired cognition; required total assistance with bed mobility, transfers, dressing, and toilet use; and was unsteady but able to stabilize with staff assistance when completing surface-to-surface transfers. According to the MDS, the resident had functional limitation in range of motion of the bilateral lower extremities, used a wheelchair, had no falls, and did not use bed (side) rails.
- The resident's care plan dated 04/06/21, indicated the resident was at risk for falls due to medications and had "a history of dementia with agitated delirium and…PTSD and

Parkinson's disease." Approaches stated, "Staff to educate the veteran about using the call light for help and utilize the bed/chair alert." The care plan did not address the use of side rails.

- A side rail safety assessment dated 08/12/19 indicated the resident had "imbalance" and "poor bed mobility" and recommended the use of two upper side rails (nearest the head of the bed). No additional side rail assessment had been conducted by staff. There was no documentation provided to indicate that alternatives were attempted prior to use of side rails, the resident was informed about the risks and benefits of side rail use, or that the CLC obtained informed consent for use of the side rails.
- On 05/19/21 at approximately 9:15 a.m. during the initial tour, the nurse manager (NM) indicated that the CLC did not utilize side rails and "if siderails are used it is the top two only."
- On 05/19/21 at approximately 9:35 a.m. and at 11:55 a.m., Resident #401 was observed lying in bed with the upper two side rails in the raised position. The resident was leaning to the right side with the resident's head on a pillow and the pillow against the upper rail.
- On 05/20/21 at 8:55 a.m., Resident #401 was observed lying in bed with the two upper and one lower side rails (nearest the foot of the bed) on the right side of the bed in the raised position. When the upper and lower side rails were raised on the right side of the bed, there was a gap of approximately three to five inches between the upper and lower side rails. On 05/20/21 at 9:25 a.m., the nursing assistant who last provided care for the resident stated, "When I turned the resident over I forgot to put the bottom [lower] rail down." The NM liaison who was present during the interview stated, "The standard is for only two side rails to be up."
- During the survey, the resident was observed performing active range of motion of the upper extremities.
- On 05/21/21 at 8:45 a.m., Resident #401 was observed lying in bed with the upper two side rails and the lower side rail on the right side of the bed in the raised position, creating a gap of approximately three to five inches on the right side of the bed between the rails. The NM liaison lowered the right side rail nearest the foot of the bed.
- In summary, Resident #401 was observed leaning to the right while in bed with his head on a pillow that was against the raised upper side rail. During additional observations, three side rails were raised (two upper and one lower) although staff indicated the "standard is for only two side rails to be up" and "if siderails are used it is the top two only." The resident had a diagnosis of Parkinson's disease and was observed performing active range of motion of the upper extremities, suggesting a risk for contact with the side rails. The last side rail safety assessment was dated 08/12/19. There was no documentation provided to indicate that alternatives were attempted prior to use of side rails, the resident was informed about the risks and benefits of side rail use, or that the CLC obtained informed consent for use of the side rails. The resident's plan of care did not address side rail use.

F693

483.25(g)(4)(5) *§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the*

Based on observation, interview and record review, the CLC did not ensure a resident with a percutaneous endoscopic gastrostomy (PEG) tube received appropriate treatment and services to prevent complications. Findings include:

During an interview with a registered nurse (RN) liaison on 05/20/21 at 1:30 p.m., the RN indicated there was not a CLC policy for use of sterile water when administering medication through a feeding tube. The RN stated that when the CLC did not have a specific policy, staff used Elsevier's for reference. Elsevier's Clinical Skill was obtained online; the policy was titled, "Feeding Tube: Medication Administration" and dated October 2020. The policy stated, "Use purified or sterile water for flushing and medication preparation."

facility must ensure that a resident — §483.25(g)(4)-(5) Enteral Nutrition §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.

Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy

Residents Affected - Few

Resident #106, [LOCATION]

- Resident #106 was admitted to the CLC on [DATE] with diagnoses that included cerebrovascular accident (CVA), dysphagia and aspiration pneumonia.
- On 05/19/21 at 5:00 p.m., a different RN than the RN liaison was observed administering medications through Resident #106's PEG tube, as indicated in the provider orders for May 2021. The RN crushed Xarelto 20 milligrams (mg) and metformin 500 mg, placed each medication in a medicine cup and added tap water to each cup. The RN emptied silodosin 8 mg into a medicine cup and added tap water to the cup. The RN flushed the resident's G-tube with 30 milliliters (ml) of tap water prior to administering the medications, flushed with 15 ml of tap water between each medication and flushed with 30 ml of tap water after administration of all of the medications.

F697

483.25(k) *§483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.*

Level of Harm - Actual harm that is not immediate jeopardy

Residents Affected - Few

Based on observation, interview and record review, the CLC did not provide pain management for a resident who required such services. Findings include:

The CLC policy titled, "Pain Management," was dated March 1, 2016, and provided on 05/19/21. According to the policy, "(b) A comprehensive pain assessment (In-dept Pain Template) is completed if the pain score is 4 or greater or if the patient is receiving pain medication. The pain assessment is completed at the time of admission, with each new onset of pain and by the receiving unit upon transfer. A pain assessment is completed for each site of pain. It is then forwarded to the Practitioner (Physician, PA [physician assistant], APN [advanced practice nurse]) as an identified signer to notify them of the elevated/change in pain. (c) Reassessment is completed and documented in the progress notes (Pain Reassessment Template). A reassessment is completed daily after the comprehensive pain assessment is completed until the patient reports satisfaction with his pain management. Additional reassessments are conducted when there is: (1) sudden and/or unusual increase in pain; (2) patient is not satisfied with his/her pain relief; and (3) pain management treatment plan is modified. It is then forwarded to the Practitioner (Physician, PA, APN) as an identified signer to notify them of the elevated/change in plan."

Resident #403, [LOCATION]

- Resident #403 was admitted to the CLC on [DATE] following a right proximal tibia/fibula fracture. During the initial tour on 05/19/21 at approximately 9:00 a.m., an RN stated that Resident #403 had pain but "it has resolved with range of motion."
- According to the resident's comprehensive MDS dated 04/08/21, the resident was understood and understood others, had a Brief Interview for Mental Status (BIMS) score of 9 suggesting moderately impaired cognition, rejected care four to six days during the assessment period, and required extensive assistance with bed mobility, and total assistance with transfers and dressing. The MDS indicated the resident had functional limitations in one upper and one lower extremity; and received scheduled pain medication, received PRN pain medication or was offered and declined, and did not receive a non-medication intervention for pain. According the MDS, the resident had frequent severe pain that made it difficult to sleep at night and limited day-to-day activities.
- The resident's care plan dated 04/05/21 addressed pain and stated, "Lower extremity pain related to fractured right tibia on 03/24/21." Approaches dated 04/19/21 stated, "Staff to monitor severity, frequency, location, and if med [medication] ineffective." Provider orders included on the care plan stated, "Acetaminophen tab [tablet] 650 mg [milligrams] po [oral] tid [three times a day] for leg pain. 1% gel top [topical] 1% grams topical QID [four times a day] for pain, use on R [right] ankle….Gabapentin cap [capsule] oral 200 mg po q [every] 8 hours, Tramadol tab 25 mg oral BID [twice daily] prn [as needed] when pain score is greater than 8." The care plan did not identify the resident's pain intensity goal. There were no non-pharmacological approaches addressed on the plan of care.
- Resident #403's most recent pain assessment dated 04/06/21 indicated the resident had a pain score of 5 related to the right lower extremity; the pain at its worst was 10 and at its best was 5 (on a scale of 0 to 10 with 10 being the worst pain possible). The assessment did not address the resident's pain intensity goal. The assessment indicated the resident's pain would come and go, was aggravated by bending and walking, and affected the resident's quality of life related to mobility.
- The pharmacy review dated 04/05/21 indicated, "He [Resident #403] has ongoing R [right] medial knee pain. Sometimes has HA [headache] related to pain. Vet [Veteran] has had somnolence related to opioids this admission. Appears to be tolerating Tramadol better than APAP/HC [acetaminophen/hydrocodone] or morphine….APAP 1000 MG tid [three times a day] started." 04/08/21 - "In [an] effort to minimize use of opioIds…vet has reported he finds APAP ineffective but has been largely compliant with taking doses."
- According to the pain clinic report dated 04/21/21, "The resident would like something for pain but not narcotics stating, 'They want to give me Tylenol and that doesn't work.'" The plan from the pain clinic was to "defer post op [operative] pain RLE [right lower extremity] to Ortho [orthopedic] clinic and to continue current pain management."
- Resident #403 was seen in the orthopedic clinic on 04/21/21; documentation regarding the visit stated, "Pt [patient[reports having pain all over RLE…has been having ongoing pain prior to surgery…consider narcotic use as patient notes some relief."
- On 05/19/21, following the visit to the orthopedic clinic for screw removal from the right knee, documentation indicated, "Reports having pain to RLE that limits him from walking, trying to do therapy, but states he is too weak. Pain in knee, quad [quadricep], with any slight movement of RLE. Unable to bend." There were no recommendations related to pain management.
- The medication administration record (MAR) between 05/04/21 and 05/21/21 indicated PRN tramadol was administered on 05/04/21, twice on 05/05/21 and 05/07/21, 05/09/21, 05/10/21, twice on 05/11/21, 05/12/21, and every day between 05/16/21 and 05/21/21 including twice on 05/20/21 and 05/21/21. Tramadol was administered for a pain intensity between 7and 9 suggesting the resident was experiencing breakthrough pain. When the

resident's pain effectiveness score suggested ongoing pain at a level of 5 or higher following administration of the PRN tramadol (twice on 05/05/21; and once on 05/07/21, 05/09/21, 05/11/21, 05/12/21, 05/18/21, 05/19/21), documentation did not indicate approaches that were implemented to address the resident's pain. On 05/20/21, after administration of PRN tramadol at 12:37 a.m., the resident's pain level was 7 at 12:52 a.m.; there was no documentation to indicate approaches that were implemented to address the pain. At 12:09 p.m. the resident's pain level was 8 and at 1:45 p.m. the pain level was 5 with no documentation of approaches implemented to address the pain. On 05/21/21 at 3:57 a.m., the resident's pain level was 8 and at 5:45 a.m. it was 6 and there was no documentation to indicate the approaches implemented to address the pain. At 9:42 a.m., the resident's pain level was 8 (and tramadol was administered). When the PRN tramadol was administered, documentation did not address the location of the pain.

- According to the NM, as of 04/02/21 Resident #403 had been receiving kinesiotherapy five times a week at 10:30 a.m. for strengthening, ROM, transfer training and ambulation. Progress notes related to the kinesiotherapy included the following:
    - 05/13/21 - "10/10 pain reported in RLE. Pt. consistently states pain in medial knee."
    - 05/14/21 - "Did not participate."
    - 05/17/21 - "No pain stated during session."
    - 05/18/21 - "6/10 pain reported at beginning of session."
    - 05/19/21 - "Did not participate."
    - 05/20/21 - "7.5/10 pain reported at beginning of session prior to exercise."
    - 05/21/21 - "7.5/10 pain reported at beginning of session prior to exercise."
- There was no documentation provided indicating that Resident #403 received medication prior to the kinesiotherapy sessions.
- On 05/19/21 at 4:50 p.m., the resident was observed lying in bed. The resident said, "The girls [staff] are great" but did not respond when asked about pain management.
- On 05/19/21 at 5:00 p.m., the NM indicated that the resident was seen by orthopedic staff today and "they took out a pin and shortened his cast…we had a hard time getting a hold of his pain. We focused on getting his pain under control. He's come a long way." The NM indicated that the resident received pain medication prior to leaving for the clinic at 9:30 a.m.; the resident returned at approximately 1:15 p.m.
- On 05/21/21 at 9:55 a.m., Resident #403 was observed lying on his back in bed with the head of the bed raised approximately 45 degrees. The resident was lying on a low air loss mattress and had both lower legs elevated on top of pillows. The [LOCATION] wound care RN, a second RN, and a nursing assistant were present during the observation, along with the nurse manager, RN liaison and RN observers from the CLC and quality management team. During the observation, the resident was positioned to the right side and the [LOCATION] wound care RN provided hygiene care and performed a dressing change. After the dressing change, Resident #403 was assisted to his back; the wound RN and nursing assistant lifted the resident's right leg onto a pillow while the resident's right foot appeared to be shaking. During the movement, the resident called out in a loud tone of voice and raised his right hand to his forehead and covered his eyes. When staff were asked by a surveyor if the resident was experiencing pain or discomfort, the wound care RN asked the resident if he was experiencing pain. The resident stated, "Yes. My knee." The nurse manager asked the resident to describe the pain on a zero to ten pain scale and the resident indicated the pain was at an intensity level of "seven or eight" in the "right leg." The wound care RN stated, "He was medicated 30 minutes ago." The staff continued to provide care by assisting the resident with use of a body sling to transfer out of bed to his wheelchair. The nurse manager stated, "He is going to therapy for strengthening [after being transferred out of bed]." The nurse manager stated, "He came to us in such a great deal of pain. If he lays [in bed] he gets sores…we tried to get a hold of his pain. He won't move." The nurse manager indicated that on 05/20/21 the resident "spent the whole day in the ortho clinic…they took out a screw."

Staff did not offer pharmacologic or non-pharmacologic approaches to address the resident's pain before continuing care or before therapy.

- On 05/21/21 at approximately 11:00 a.m., the NM stated, "It takes more than two to do dressing changes because he is in so much pain every day, just moving him." When asked if any non-pharmacological approaches to address the pain had been attempted, the NM said, "No." According to the NM, when staff administered a PRN pain medication they were to document the pain rating and then the effectiveness of the medication. If the medication was not effective in reducing the resident's pain, staff were "to page the physician." The NM reviewed nursing documentation related to administration of the PRN tramadol and indicated that the physician had not been contacted when the medication was ineffective; the NM did not clarify what was meant by "ineffective." When asked about the provider not being notified including when the resident's pain was not relieved on 05/20/21 and 05/21/21, the NM said, "There is no definite answer."
- In summary, on 05/21/21, during hygiene care and a dressing change the wound RN and nursing assistant lifted the resident's right leg onto a pillow while the resident's right foot appeared to be shaking. During the movement, the resident called out in a loud tone of voice and raised his right hand to his forehead and covered his eyes. When staff were asked by a surveyor if the resident was experiencing pain or discomfort, the wound care RN asked the resident if he was experiencing pain. The resident stated, "Yes. My knee," and indicated the pain was at an intensity level of "seven or eight" in the "right leg." The staff continued to provide care and assisted the resident to transfer to his wheelchair; the nurse manager stated, "He is going to therapy for strengthening [after being transferred out of bed]." Staff did not offer pharmacologic or non-pharmacological approaches to address the resident's pain before continuing care or before therapy. Resident #403 had a provider's order that stated, "Tramadol tab 25 mg oral BID [twice daily] prn [as needed] when pain score is greater than 8." Between 05/04/21 and 05/21/21 PRN tramadol was administered on 05/04/21, twice on 05/05/21 and 05/07/21, 05/09/21, 05/10/21, twice on 05/11/21, 05/12/21, and every day between 05/16/21 and 05/21/21 including twice on 05/20/21 and 05/21/21. Tramadol was administered for a pain intensity between 7 and 9 suggesting the resident was experiencing breakthrough pain. When the resident's pain effectiveness score suggested ongoing pain at a level of 5 or higher following administration of the PRN tramadol, documentation did not address approaches that were implemented to address the resident's pain. On 05/20/21, after administration of PRN tramadol at 12:37 a.m., the resident's pain level was 7 at 12:52 a.m.; there was no documentation to indicate approaches that were implemented to address the pain. On 05/21/21 at 3:57 a.m., the resident's pain level was 8 and at 5:45 a.m. it was 6 and there was no documentation to indicate the approaches implemented to address the pain. When PRN tramadol was administered, documentation did not address the location of the pain. The care plan did not identify the resident's pain intensity goal or address non-pharmacological approaches to address the pain.

Page Footer